

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers—Pages 1 and 2—should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
16738 CERTIFICATE OF DEATH 16733

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Port Republic</u> c. LENGTH OF STAY IN 1b <u>yes</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>—</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Scientist's Cliffs</u> d. STREET ADDRESS <u>Port Republic</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>Hillidge</u> Last <u>Allanson</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 4 1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>
13. FATHER'S NAME <u>Hillidge</u>		14. MOTHER'S MAIDEN NAME <u>Pritchard</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-16-7897</u>	17. INFORMANT <u>Henry F. Allanson</u> Address <u>Port Republic, Md.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Transverse Colon</u> <u>1531</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with Profuse Melina</u> DUE TO (c) <u>Carcinoma of Transverse Colon</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 hr.</u> <u>Since Jan. '67</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan.</u> , 19 <u>67</u> , to <u>Dec. 4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec. 4</u> , 19 <u>67</u> , and that death occurred at <u>8:30 p.m.</u> on the causes and on the date stated above.			
22a. SIGNATURE <u>Page C. Jett</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>12-5-67</u>
22c. PHYSICIAN'S NAME (Type) <u>Dr. Page C. Jett</u>		22d. ADDRESS <u>Prince Frederick, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Dec 7/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Christ Church Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Port Republic, Md.</u>
24. FUNERAL DIRECTOR <u>A.A. Robinson Sr.</u> ADDRESS <u>Port Republic, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 7 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

10133

Station Jan. 1967  
Cantonment of Transverse Station  
with Profile Station  
Cantonment of Transverse Station

Jan. 1967  
11:30 a.m.  
12-5-67  
Station 1967  
Page 11, 1967

Page 11, 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 15-1  
30M REV. 1-68

16733										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										16734																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
First Middle Last										Month Day Year																																																	
Zellers										Berry										December 13 1967 9:45PM																																							
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN.									
Male										Negro										July 21, 1892										75 YRS.																													
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH										Md.																			
Maryland										U.S.A.																				Calvert																													
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																													
Rural-Prince Frederick										Calvert County Hospital										School Bus Contractor																																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER																			
Maryland										Calvert										Prince Frederick																																							
14. FATHER'S NAME First Middle Last										15. MOTHER'S MAIDEN NAME First Middle Last																																																	
John Henry Berry										Aletha Boome																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (es, no, or unknown)										16b. SOCIAL SECURITY NO. (If yes give war or dates of service)										17. INFORMANT Address																																							
No										214-42-2694										Leroy E. Berry										Huntingtown, Md.																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										443X										DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) Hypertensive heart Dis.										DUE TO, OR AS A CONSEQUENCE OF																																							
										(c)																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from December 13, 1967, to Dec. 13, 1967, that (I) (we) last saw the deceased alive on December 13, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED										December 14, 1967																													
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																	
Osman Z. Ersoy, M.D.										Prince Frederick, Maryland																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																													
										12/15/67										Calverton										Bowie, Calvert Co. Md.																													
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																													
Johnston										Funeral Home, Ann. Md.										DEC 18 1967										Charles Judge																													

MEDICAL CERTIFICATION



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
16740					16735						
1. PLACE OF DEATH a. COUNTY Calvert MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Prince Frederick					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick - Rural						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital					d. STREET ADDRESS						
3. NAME OF DECEASED (Type or print) First Middle Last Rufus Brooks					4. DATE OF DEATH Month Day Year December 27 1967						
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-29-91		9. AGE (In years last birthday) 76 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Benjamin Brooks					14. MOTHER'S MAIDEN NAME Suzanne Blake						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					16. SOCIAL SECURITY NO. 217-36-5305						
					17. INFORMANT Address A Medical Record's Chart						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Circumstances due</i> 1530 DUE TO <i>Ca of death</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <i>Resection of bone at Johns Hopkins Hospital</i> (b) <i>Ca of death</i> (c) <i>Resection of bone at Johns Hopkins Hospital</i>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 9					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.											
22a. SIGNATURE <i>[Signature]</i>					22b. DATE SIGNED						
22c. PHYSICIAN'S NAME (Type) Roberto de Villarreal, M.D.					22d. ADDRESS St. Leonards, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF 12-31-67		23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Ch. Cem.			23d. LOCATION (City, town or county) (State) Pr. Fred- md			
24. FUNERAL DIRECTOR <i>Linney G. Swell Pr. Frederick, Md.</i>					25a. REC'D BY REGISTRAR DATE JAN 3 1968		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

John J. ...



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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16741

16736

1. PLACE OF DEATH a. COUNTY <b>Calvert</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Prince Frederick</b>		c. LENGTH OF STAY IN lb <b>9 hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Calvert County Hospital</b>			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Manilla Veria Dixon</b>			4. DATE OF DEATH Month <b>December</b> Day <b>9</b> Year <b>1967</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/14/05</b>		9. AGE (In years last birthday) yrs. <b>62</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Alexander Dixon</b>			12. CITIZEN OF WHAT COUNTRY? <b>US</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			14. MOTHER'S MAIDEN NAME <b>Mariah Howe</b>		
16. SOCIAL SECURITY NO. <b>217-32-2818</b>			17. INFORMANT <b>Alfred Booth Owings, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>7824</b> IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on <b>Dec. 9 1967</b> , and that death occurred at <b>6:30 AM</b> , from causes on and on the date stated above.					
22a. SIGNATURE <i>[Signature]</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12-9-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>[Signature]</b>		22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>12/13/67</b>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <b>St. Edmonds Ch. Cem.</b>	
23d. LOCATION (City or Town) _____ (County) _____ (State) _____		23e. LOCATION (City or Town) _____ (County) _____ (State) _____			
24. FUNERAL DIRECTOR <b>Lindsey E. Sewell</b>		ADDRESS <b>Pr. Frederick</b>		25a. REC'D BY REGISTRAR <b>DEC 14 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

## REFERENCES

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2014/4/15

0190-9010

Александр Александрович

Health News

Alfred Booth

• *bioRxiv preprint doi: <https://doi.org/10.1101/000000>; this version posted January 1, 2016. The copyright holder for this preprint (which was not certified by peer review) is the author/funder, who has granted bioRxiv a license to display the preprint in perpetuity. It is made available under aCC-BY-NC-ND 4.0 International license.*

15/13/67 25.24m/sec 0.00

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• *DM*



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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Prince Frederick		c. LENGTH OF STAY IN 1b 28 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Aquasco		16-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Katie Edward Douglas		4. DATE OF DEATH Month 12 Day 16 Year 19 67	
5. SEX female	6. COLOR OR RACE negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-27-77
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Fowler		14. MOTHER'S MAIDEN NAME Fannie Brooks	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 213-40-9341	
17. INFORMANT Rebecca Rogers		Address Aquasco, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Melancholia</u> 4201 DUE TO <u>Cranial occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cranial occlusion</u> (c) <u>Cranial occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/18</u> , 19 <u>67</u> , to <u>Dec. 16</u> , 19 <u>67</u> , and that death occurred at <u>8:30 A.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>R de Villard</u>		22b. DATE SIGNED 12-17-67	
22c. PHYSICIAN'S NAME (Type) R de Villard		22d. ADDRESS St. Leonard, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF Dec. 21-1967	
23c. NAME OF CEMETERY OR CREMATORY John Wesley Ch. Cem.		23d. LOCATION (City or Town) (County) (State) Aquasco P. Geo's Md.	
24. FUNERAL DIRECTOR Martell Adams		25a. REC'D BY REGISTRAR DATE DEC 26 1967	
25b. REGISTRAR'S SIGNATURE Charles Jones			

1071

OFFICE OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

16743

16738

1. PLACE OF DEATH a. COUNTY <b>Calvert</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland 20657</b> b. COUNTY <b>Calvert</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Prince Frederick</b>		c. LENGTH OF STAY IN lb <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Lusby</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Calvert County Hospital</b>				d. STREET ADDRESS <b>Box 83</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Bernard William Earhart</b>				4. DATE OF DEATH Month Day Year <b>December 4 19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-30-1900</b>		9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Union #48</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Benjamin Earhart</b>				14. MOTHER'S MAIDEN NAME <b>Anna Loskorn</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-14-8378</b>		17. INFORMANT Address <b>Catherine Earhart, Lusby, Maryland 20657</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive retro peritoneal</b> <b>452X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hemorrhage</b> DUE TO (c) <b>Ruptured Aneurysm.</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>December 3, 19 67</b> , to <b>December 4 19 67</b> , that (I) (we) last saw the deceased alive on <b>December 4 19 67</b> , and that death occurred at <b>7:15 AM</b> , from causes and on the date stated above							
22a. SIGNATURE <b>Isaam F. el Damalouji, M.D.</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Isaam F. el Damalouji, M.D.</b>				22d. ADDRESS <b>Prince Frederick, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-8-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Co. Md.</b>	
24. FUNERAL DIRECTOR <b>Lasson Funeral Home 7401 Blum Rd</b>				25a. REC'D BY REGISTRAR <b>DEC 7 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Calvert</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sunderland</b>		c. LENGTH OF STAY IN lb <b>04.1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Calvert County Hospital</b>		d. STREET ADDRESS <b>Sunderland, Maryland</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>DORIS MAE GIBSON</b>		4. DATE OF DEATH Month Day Year <b>December 19 19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 8, 1925</b>
9. AGE (In years last birthday) <b>42</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery</b>	
11. BIRTHPLACE (State or foreign country) <b>Calvert Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>J. Albert Dowell</b>		14. MOTHER'S MAIDEN NAME <b>Bertha M. Turner</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>- - -</b>		16. SOCIAL SECURITY NO. <b>- - -</b>	
17. INFORMANT <b>Joseph Gibson</b>		Address <b>Sunderland, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>981X</b> IMMEDIATE CAUSE (a) <b>Gunshot wound of the back</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Found on floor in store</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>2:00</b> p.m. <b>12 19 67</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Store</b>		20f. (City or town) (County) (State) <b>Sunderland Calvert Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>December 20, 1967</b>	
ACTUAL SIGNATURE <b>Edward F. Wilson</b> EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
23b. DATE THEREOF <b>Dec. 22, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>All Saints Chr. Cemetery</b>	
23d. LOCATION (City or Town) (County) (State) <b>Sunderland, Cal. Maryland</b>		24. FUNERAL DIRECTOR <b>Hutchins Funeral Home Owings, Md.</b>	
25a. REC'D BY REGISTRAR <b>DEC 29 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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J. Albert Doherty

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
16745  
16740  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Calvert</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. LENGTH OF STAY IN ID <i>Life</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>—</i>		e. STREET ADDRESS <i>(rural)</i>	
3. NAME OF DECEASED (Type or print) First <i>Tamara</i> Middle <i>Bowen</i> Last <i>Hammitt</i>		4. DATE OF DEATH Month <i>Dec.</i> Day <i>22</i> Year <i>1967</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 12, 1959</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None (Child)</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Calvert Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Hammitt</i>		14. MOTHER'S MAIDEN NAME <i>Faye Bowen</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>J. John Hammitt</i>		Address <i>Prince Frederick Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Indistinct</i> 355X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Brain Damage (Congenital)</i> (c) <i>—</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Senior Center</i>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>12/22/67</i> , 19 <i>67</i> , to <i>12/22/67</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>19</i> , and that death occurred at <i>12/22/67</i> , M, from the causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED <i>12/22/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Dr. C. W. BARRETT</i>		22d. ADDRESS <i>St. Leonard, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Dec. 23, 1967</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Central Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Barstow Calvert Co. Md.</i>	
24. FUNERAL DIRECTOR <i>A. A. Harkness &amp; Son</i>		ADDRESS <i>Port Republic, Md.</i>	
25a. REC'D BY REGISTRAR <i>[Signature]</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
DATE <i>DEC 28 1967</i>			

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Handwritten notes and signatures, including "J. B. Collins" and "J. B. Collins" in the bottom right corner.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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16746		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		CERTIFICATE OF DEATH		16741	
1. PLACE OF DEATH a. COUNTY <b>Calvert</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Prince Frederick</b>		c. LENGTH OF STAY IN lb <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sunderland-Rural</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Calvert County Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Elias</b>		First Middle Last <b>Jones</b>		4. DATE OF DEATH Month <b>December</b> Day <b>30</b> Year <b>1967</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-2-95</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Levi Jones</b>				14. MOTHER'S MAIDEN NAME <b>Alice Parran</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>218-12-9222-A</b>		17. INFORMANT <b>Self-Hospital Admission</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart dis</b> DUE TO (c) .						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <b>12/30</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>12/30</b> , 19 <b>67</b> , and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE <b>Osman Z. Ersoy, M.D.</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Osman Z. Ersoy, M.D.</b>				22d. ADDRESS <b>Prince Frederick, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>1-3-68</b>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <b>St. Edmonds Ch. Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Calvert Co. Md</b>	
24. FUNERAL DIRECTOR <b>Linkeney &amp; Sewall</b>				ADDRESS <b>Prince Frederick Md</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 3 1968</b>	
						25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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REPORT OF THE

Director

of the

Department

of Agriculture

and

Commerce

for the year 1922

Washington, D. C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (A)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16742

CERTIFICATE OF DEATH

16742

1. PLACE OF DEATH a. COUNTY <b>Calvert</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings (Rural)</b>		c. LENGTH OF STAY IN lb <b>6½ years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Padgett's Nursing Home</b>		d. STREET ADDRESS <b>Shady Side</b>	
3. NAME OF DECEASED (Type or print) <b>(Eliza)<sup>first</sup> NELLIE WAYSON LINTON</b>		4. DATE OF DEATH Month <b>December</b> Day <b>16</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 24, 1883</b>
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Anne Arundel Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Lewis P. Wayson</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth A. Simmons</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>-----</b>		16. SOCIAL SECURITY NO. <b>D 219-14-0437</b>	
17. INFORMANT <b>Mrs. Annie Ward, Lothian, Maryland 20820</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>334X</b> IMMEDIATE CAUSE (a) <b>Cerebral arteriosclerosis</b> DUE TO (b) <b>generalized arteriosclerosis</b> DUE TO (c) <b>Years</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic pyelitis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>—</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>August, 1966</b> to <b>December 1967</b> that (I) <b>(was)</b> last saw the deceased alive on <b>12/16/67</b> , and that death occurred at <b>9:35 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Charles H. Wirth MD</b>		22b. DATE SIGNED <b>12/17/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles H. Wirth MD</b>		22d. ADDRESS <b>Lothian, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 19, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Quaker Burying Ground</b>		23d. LOCATION (City or Town) (County) (State) <b>Galesville Anne Arundel, Md.</b>	
24. FUNERAL DIRECTOR <b>Hutchins Funeral Home</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
ADDRESS <b>Owings, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
DATE <b>DEC 20 1967</b>			

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other person is necessary, the certificate should be executed by the medical examiner, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Calvert</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>HENDRICKS LYONS</b>						4. DATE OF DEATH Month <b>December</b> Day <b>18</b> Year <b>1967</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 2, 1885</b>		9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months <b>82</b> Days <b>82</b> Hours <b>82</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer (retired)</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Calvert Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Lyons</b>						14. MOTHER'S MAIDEN NAME <b>Leevinia Harrison</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>- - -</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>215-14-2790</b>		17. INFORMANT <b>H. Arnold Lyons, Owings, Maryland</b>		Address <b>20836</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>7824</b> (c) <b>DUE TO</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Dropped dead at supper table</b>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year <b>5:40 p.m. 12/18 1967</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Owings</b> (County) <b>Calvert</b> (State) <b>MD</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>H W Ward</b> EXAMINER'S NAME (Type) <b>H. W. Ward</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>12/18/67</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Dec. 21, 1967</b>		22c. NAME OF CEMETERY OR CREMATORY <b>All Saints Chr. Cemetery</b>		22d. LOCATION (City, town, or county) <b>Sunderland</b> (State) <b>Calvert Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 29 1967</b>	
23. FUNERAL DIRECTOR <b>Hutchins Funeral Home</b> ADDRESS <b>Owings, Maryland</b>						24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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CAUSE OF DEATH

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DATE OF DEATH

CAUSE OF DEATH

Swine

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 16744									
1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Calvert</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Leonard</u>			c. LENGTH OF STAY IN 1b <u>1 1/2 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Leonard</u> 04-1				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>—</u>					d. STREET ADDRESS <u>Point Farm - Boyse</u>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Gracie</u> Last <u>McGhie</u>					4. DATE OF DEATH Month <u>Dec.</u> Day <u>27</u> Year <u>1967</u>				
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 26 1907</u>		9. AGE (In years last birthday) <u>60 yrs.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>(Caretaker)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Caretaker - Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Glasgow - Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>British</u>	
13. FATHER'S NAME <u>Archibald McGhie</u>					14. MOTHER'S MAIDEN NAME <u>Helena Nobles</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>			16. SOCIAL SECURITY NO. <u>214 56-7529</u>		17. INFORMANT Address <u>Mrs. Georgina McGhie, St. Leonard, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis - acute</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Insuff.</u> DUE TO (c) <u>—</u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> a. m. <u>—</u> p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>Issam Damabaji</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>Issam Damabaji</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>Dec. 28, 1967</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Leider Hill Crematory</u>			22d. LOCATION (City, town, or county) (State) <u>Suitland Rd., Washington, D.C.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. C. Harrison &amp; Son, Port Republic, Md.</u>					24a. REC'D BY REGISTRAR DATE <u>JAN 2 1968</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

# MASSACHUSETTS DEPARTMENT OF HEALTH MEDICAL EXAMINER'S CERTIFICATE OF DEATH

PLACE OF DEATH HOME		DECEASED NAME	
CITY OR TOWN OF DEATH BOSTON		DECEASED SEX	
DECEASED AGE		DECEASED OCCUPATION	
DECEASED MARITAL STATUS		DECEASED COLOR	
DECEASED RELIGION		DECEASED EDUCATION	
DECEASED PLACE OF BIRTH		DECEASED DATE OF BIRTH	
DECEASED DATE OF DEATH		DECEASED TIME OF DEATH	
DECEASED CAUSE OF DEATH		DECEASED MANNER OF DEATH	
DECEASED SIGNATURE OF EXAMINER		DECEASED SIGNATURE OF WITNESS	

*Coroner's Report*

*Coroner's Report*

*Paul J. ...*

CIVIL RIGHTS DIVISION  
 DEPARTMENT OF JUSTICE  
 WASHINGTON, D.C. 20540

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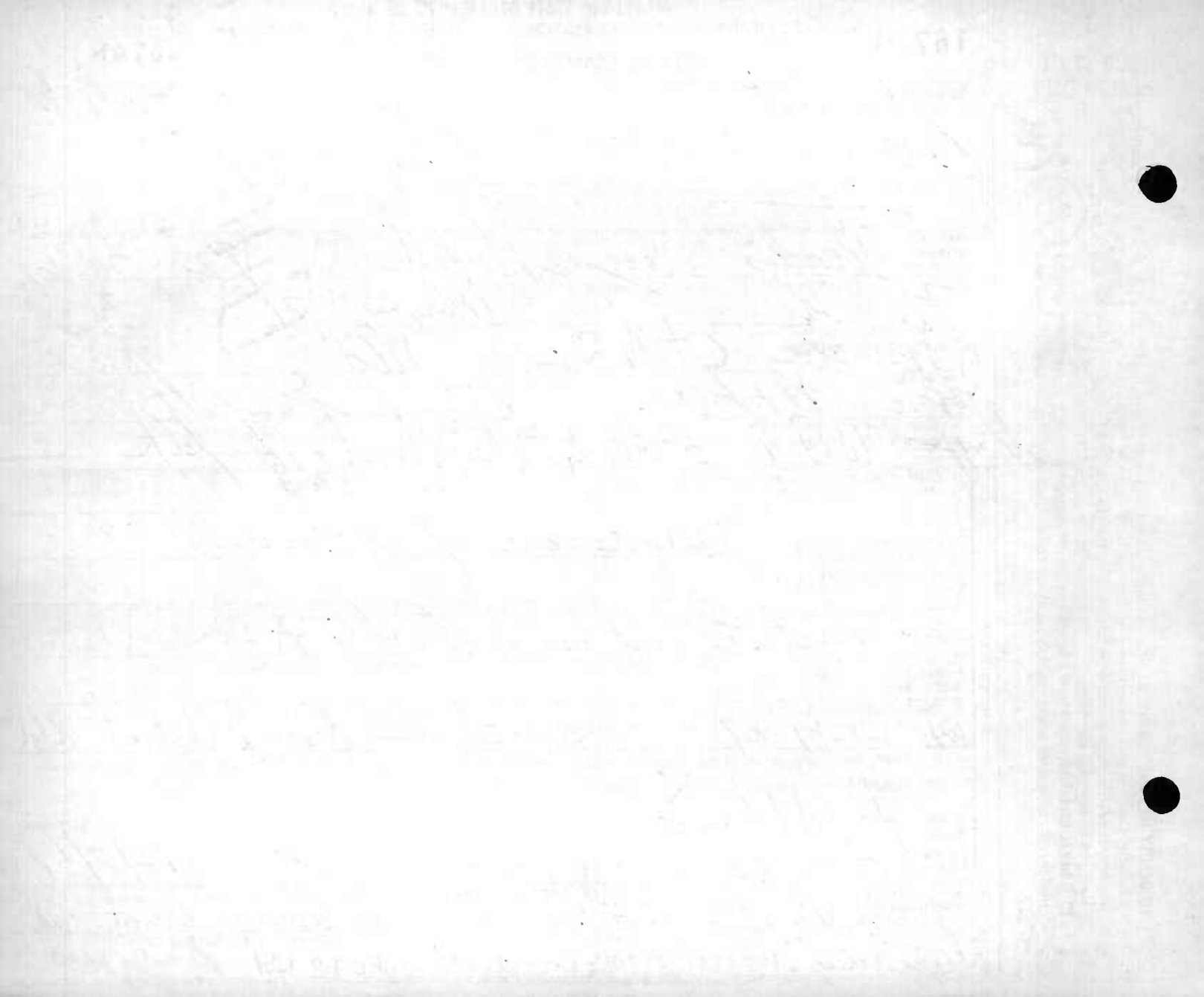
FOR STATE  
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dwight MD</u>		c. LENGTH OF STAY IN 1b -	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Charles Wesley Norfolk</u>		4. DATE OF DEATH Month <u>12</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 23, 1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <u>71</u>
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John Norfolk</u>		14. MOTHER'S MAIDEN NAME <u>Emma Griffith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes WW II</u>		16. SOCIAL SECURITY NO. <u>578-18-85</u>	
17. INFORMANT <u>Mrs. Charles Norfolk</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>7824</u> DUE TO <u>Cardiac Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) <u>Cardiac Failure</u> DUE TO (c) <u>Cardiac Failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead in bed at 9 AM</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>1045</u> <u>12/7/67</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Home</u>	20f. (City or town) <u>Dwight</u> (County) <u>Calvert</u> (State) <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>H. W. Ward</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. WARD</u> <u>Owings, MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-10-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt Harmony Ch. Cem</u>	23d. LOCATION (City or Town) <u>Owings</u> (County) <u>Calvert</u> (State) <u>MD</u>
24. FUNERAL DIRECTOR <u>Hutchinson Funeral Home Owings, MD</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
		25b. REGISTRAR'S SIGNATURE	
		DATE <u>DEC 12 1967</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
16746										
1. PLACE OF DEATH a. COUNTY <b>Calvert</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Prince Frederick</b>			c. LENGTH OF STAY IN 1b <b>4 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Owings</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Calvert County Hospital</b>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Tyranzo Marvin Smith</b>					4. DATE OF DEATH Month <b>12</b> Day <b>10</b> Year <b>1967</b>					
5. SEX <b>male</b>		6. COLOR OR RACE <b>negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-19-67</b>		9. AGE (In years last birthday) yrs. <b>5</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Calvert, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Marvin Sylvester Smith</b>					14. MOTHER'S MAIDEN NAME <b>Madeline Theresa Smith</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Marvin Sylvester Smith, Owings, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>571.0</b> DUE TO <b>Death (undetermined)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Death (undetermined)</b> DUE TO <b>Death (undetermined)</b> (c) <b>Death (undetermined)</b>									INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 6</b> , 19 <b>67</b> , to <b>Dec. 10</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>Dec. 10</b> , 19 <b>67</b> , and that death occurred at <b>10:30 AM</b> , from causes and on the date stated above.										
22a. SIGNATURE <b>Roberto de Villarreal</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <b>Roberto de Villarreal, M.D.</b>					22d. ADDRESS <b>St. Leonard, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-13-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope Church</b>			23d. LOCATION (City or town) (County) (State) <b>Calvert, Maryland</b>			
24. FUNERAL DIRECTOR <b>George E. Berry Huntington, Md.</b>					25a. REC'D BY REGISTRAR DATE <b>DEC 14 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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